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CHRONICLE OF THE WORLD HEALTH ORGANIZATION

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SCHEDULE OF MEETINGS

12 January **Executive Board, eleventh session, Geneva**

Included on the agenda of this session are regional matters; review of programme and budget estimates for 1954; expanded programme of technical assistance for economic development; organizational studies of (1) the education and training programme, including fellowships, and (2) regionalization; International Sanitary Regulations; medical supply services to Member States; review of reports of expert committees; and various other items relative to administrative matters and to the Sixth World Health Assembly.

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THE TRUE PROMISE OF TOMORROW

Message of the Director-General on the occasion of United Nations Day, 24 October 1952.

One of the important handicaps we will have to overcome in our efforts to build a better world is the sense of discouragement and frustration which prevails in many countries as to the role the United Nations is playing and can play in securing lasting peace and security for all nations. The main reason for this unhappy situation can be found, I believe, in a lack of understanding by many of us of the tremendous problems the United Nations and its specialized agencies are facing, as well as in our failure to appreciate adequately the slow but significant advances these organizations have been making since 1946 toward a solution of those problems.

The man in the street is hardly to blame for this attitude. The story his daily newspaper and radio have been telling him for the last six years is almost entirely about disagreements and tension between nations, about discussions and meetings ending in failure, and generally about all disruptive aspects of the international life. No wonder then that his belief in the concepts underlying the work of the United Nations is being shattered and that his support for any organized action to bring nations together is still weak.

It is time for all those whose noble mission it is to mould and educate public opinion to remember that the most important news in the world today is that which marks progress toward the kind of existence to which we all must devote our energies, that is, a world of peace, co-operation, and prosperity.

It is indeed fitting that on this United Nations Day we should occupy our minds with constructive considerations rather than the defeatist philosophy which holds that history must repeat its errors, but never its successes.

It is most important not to regard with undue pessimism the disputes between the nations which make the daily headlines. While man is working his slow way toward peace, he must also be talking and arguing a way toward it. The world we all want will not be created by coining slogans, but by the open discussion of our differences. We should not be misled by the headlines : we must think of the lines behind them.

One of the things that should be remembered is this : in most of the countries of the world today there are teams of international workers sent by the United Nations and its agencies, and freely invited by the governments of the countries concerned, whose sole aim is to help those governments improve the health, the education, the economic and labour conditions, and the farming skills and systems of their citizens so that they may have true prosperity and happiness.

This is the real news of today, the news that does not often appear, even in the small type and the three-line item.

There is, for instance, a New York nurse who six years ago was working for UNRRA to aid the people of war-torn Greece. Today she is still far from home, helping to train in Israel the nurses who are one of that country's great needs.

On the same day in August that she set off from WHO's headquarters, another girl left her native Sweden to help in Egypt's fight against tuberculosis, a Dutch doctor took a plane to Ethiopia to assist the Government in building up its public-health services, and a public-health engineer from Minnesota found himself on the way to Ankara, in Turkey. All this happened in one day and in one specialized agency.

Yet every day throughout the year from the United Nations and from all of its specialized agencies such pioneers in the cause of peace and understanding are going about the true business of the world.

In their work lies the true promise of tomorrow. The story of what they are doing will be an encouragement for the millions of peoples throughout the world who can make the idea of a united world a living reality.

ENDEMIC SYPHILIS IN BOSNIA

Five years ago the Yugoslav Government requested the World Health Organization and the United Nations International Children's Emergency Fund (UNICEF) to participate in its programme to control endemic syphilis in Bosnia. Supplies and equipment were furnished by UNICEF ; WHO sent experts to conduct a preliminary field investigation and, later, to study the various phases of development of the programme itself. The planning, implementation, and follow-up of the programme were the responsibility of the Yugoslav Government. Dr. E. I. Grin, Director of Health, Central Dispensary for Skin and Venereal Diseases, Sarajevo, submitted a complete report to WHO on the campaign, which is now drawing to a close. This article is a summary of that report.[1]

Bosnia-Herzegovina

The area which today forms the People's Republic of Bosnia and Herzegovina has, in the course of history, been the theatre of a number of invasions. The Romans conquered it and governed it during four centuries ; the first Slavs invaded it in the 7th century ; and it was an area of conflict between Eastern and Western civilizations until the 15th century, when it was overrun by the Turks. It remained under Turkish rule until

[1] Grin, E. I. (1952) *Endemic syphilis in Bosnia*, Geneva (*World Health Organization : Monograph Series*, No. 11), 86 pages, price : 5/-, $1.00, or Sw. fr. 4.— (English edition)

1878 ; and the Austrians occupied it from 1878 to 1914. After the first World War, Bosnia-Herzegovina became a part of Yugoslavia. Finally, after the second World War and the struggle for independence, it became a People's Republic within the Federal People's Republic of Yugoslavia.

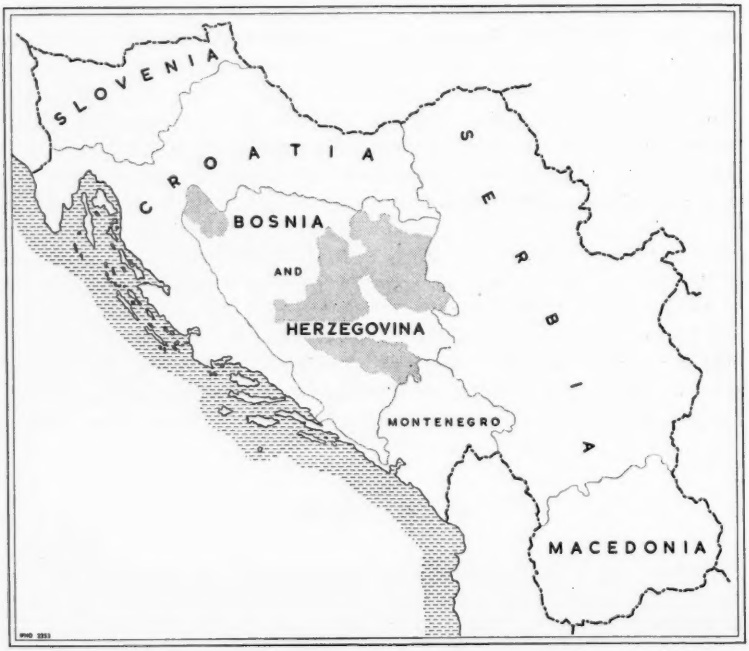
Bosnia-Herzegovina is a mountainous region, with extensive forests ; communication is frequently difficult. The fact that economic and social progress has been very slow and that the population, numbering about 2,565,277, should long have remained very little educated may be explained by topographical and historical factors. At the end of the first World War, 87% of the population was still totally illiterate ; only 1 Moslem woman in 1,000 could read or write. As late as 1939, there was still a high percentage of illiteracy : 56.4% of the men and 87.6% of the women. Since the end of the second World War, however, there has been considerable progress ; and, by the end of the scholastic year 1949-50, some 600,000 persons had learned to read and write. Sarajevo, the chief city of Bosnia, has had a university since 1949. Today, industrialization is developing fairly rapidly. The population of Sarajevo has increased considerably during recent years.

Syphilis in Bosnia

Syphilis was a serious problem in Bosnia as early as the 19th century. An attempt was made to evaluate the prevalence of the disease in a number of districts during the period of Austrian rule ; although the methods used were inadequate, investigations carried out between 1905 and 1911 showed that 8% of the population suffered from the disease. Further investigations were carried out during the inter-war period, particularly between 1926 and 1933, in an attempt to organize a syphilis-control programme; during this period serological examinations were performed, and an infection-rate of 11.8% was found. However, until the second World War, attempts to control the disease were effective only in limited areas as, for instance, close to large population centres where it was relatively easy to carry out a continuous campaign; isolated or inaccessible areas were little affected, and the situation remained serious.

The reasons for the failures of these early efforts are numerous. Both experience and adequate means were lacking ; examinations and case-finding were carried out over restricted areas instead of covering the entire infected region; the epidemiological aspects of the problem were not considered; and there were long interruptions in the work. Finally, treatment with arsenicals and bismuth, which was the only treatment then known, was not suitable for mass work; and the traditional way of living of the people and the lack of sanitation created a favourable environment for the recurrence of cases and for the perpetuation of the disease. The

FIG. 1. PREVALENCE OF ENDEMIC SYPHILIS IN BOSNIA AND HERZEGOVINA, 1951



second World War gave rise to new endemic foci as a result of the migration of refugees and of a further deterioration in sanitation. Fig. 1 shows the areas where syphilis was endemic in 1951.

The Concept of Endemic Syphilis

The endemic syphilis of Bosnia is the same disease as sporadic venereal syphilis, and there are no essential differences in the nature of the symptoms, cardiovascular and neurological involvement occurring in both. But endemic syphilis is not venereally transmitted, and the population does not consider it as a venereal disease; it affects both sexes at all ages but is most frequently acquired in childhood. The rarity of transmission by venereal contact is due to the fact that, by the time persons have reached a marriageable age, any infection which one of the partners may have contracted in childhood will already have reached a late and relatively non-infectious stage.

Endemic syphilis is a family disease, transmitted from one member of the household to another. For instance, children frequently contract it when playing with other children and introduce it into the family by first

infecting the mother who, in her turn, infects the other children and her husband. The activity of the endemic may be gauged by noting the proportion of infected children to the total number of cases found : the higher that proportion, the more active the endemic.

The most frequent mode of transmission is by the common use of kitchen or domestic utensils, particularly of drinking vessels (" ibrik ") passed from mouth to mouth (see fig. 2). The first clinical symptoms of this form of syphilis may be mucous lesions in the oral region.

Endemic syphilis is most often observed among the rural population in areas with poor economic, social, and sanitary conditions. This type of environment makes for repeated exposure to treponemes and for the spread of the disease. Syphilis became endemic in Bosnia because of the existence over centuries of epidemiological features favouring a certain mode of spread.

However, despite the fact that living conditions are equally primitive throughout the area, the distribution of endemic syphilis is very uneven in Bosnia. For instance, while in one administrative unit the general prevalence was 24.8%, it varied from 4% in one village to 60.1% in another. The reasons for this unevenness are still not clearly known ; it is probable that social and family customs, migratory factors, the topographical structure of the country, and poor communications play an important

FIG. 2. COMMON USE OF THE " IBRIK " — ONE OF THE MOST FREQUENT METHODS OF SPREAD OF ENDEMIC SYPHILIS

part. Family links and social contacts facilitate the spread of the disease, and prevalence is particularly high in those villages where most of the families are related to each other. It has also been noted that the smaller and more compact the community, the higher the infection-rate. Thus, a recent survey revealed that villages with fewer than 200 inhabitants had an average prevalence-rate of 22.5% ; those with 400 to 600 people, 12.6%; and those with over 600 people, only 9.1%.

Natural Course of Endemic Syphilis

The rarity in endemic syphilis of primary lesions normally found in venereal syphilis is explained by the particular mode of transmission in Bosnia. Mothers may sometimes show primary lesions of the breast or nipple as a result of large quantities of treponemes being transmitted from oral mucous lesions in the child during suckling. In general, however, conditions tend rather to favour the repeated transfer of small quantities of treponemes producing secondary enanthemata and exanthemata, generally in the form of localized papules in the oral region.

FIG. 3. TERTIARY LESIONS — GUMMATOUS DESTRUCTION PRODUCING NASAL DEFORMITY

The late manifestations of endemic syphilis are similar to those of venereal syphilis and include gummatous lesions on the skin, in the nasopharyngeal region, and in the osteo-articular system (arthralgia and osteoperiostitis); neurosyphilis in all forms; and cardiovascular involvement.

Tertiary lesions are, on the whole, very frequent in Bosnia; they generally occur in persons who have previously been treated for syphilis and who have remained sensitized, or in those in whom treponemes have remained which may be reactivated under the influence of various factors. Investigations have shown that when a new infection is introduced into a family,

for instance by a child who has contracted the disease outside the home, most members of the family develop early lesions; but those who have previously received treatment for syphilis may exhibit tertiary lesions caused by superinfection.

Congenital syphilis is rarely observed in Bosnia for two reasons : (1) by the time a woman is old enough to bear children, it is likely that, if she has syphilis, she contracted it many years previously, and that it is in a late, non-infectious stage, at which the risk of diaplacental infection is slight; (2) mortality among congenitally syphilitic children born in this environment is high.

Endemic syphilis seldom causes death and rarely results in total incapacity for work; it has consequently not been considered as a very serious disease in Bosnia. Gummata and other destructive lesions of the face, or involvement of the central nervous system, have no striking psychological effect upon the people. However, when living standards rise and greater social obligations are assumed, as in those regions where there is a rapid development of industrialization, the people no longer ignore the manifestations of endemic syphilis nor consider them as benign.

Organization of the Syphilis-Control Campaign in Bosnia

The programme to control endemic syphilis, which was begun in 1948, was based on the following criteria :

1. The entire population should be serologically as well as clinically examined.

2. Obligatory and adequate treatment should be given to all diagnosed cases.

3. Control examinations should include re-examination not only of all cases originally diagnosed and treated but of the remainder of the population as well.

4. Data should be recorded and control and follow-up measures taken on a family basis, and the individual cards of infected persons should constitute part of a family record.

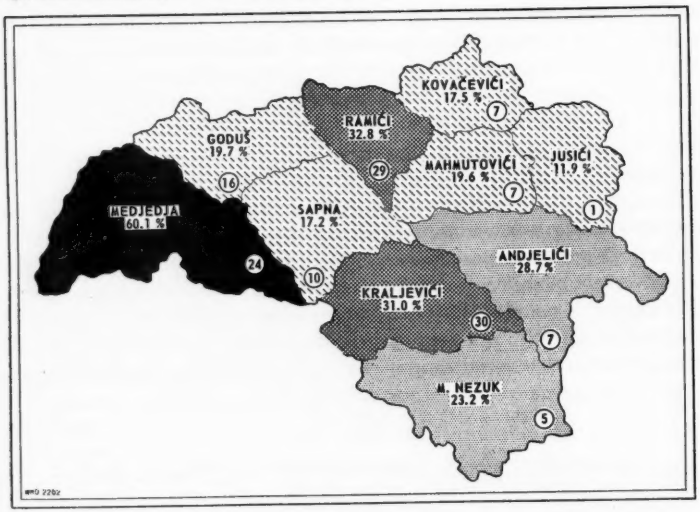
5. The active collaboration of the people should be secured and their interest in sanitation and health work stimulated.

6. The same methods and public-health principles should be applied in all the areas where the work is carried out.

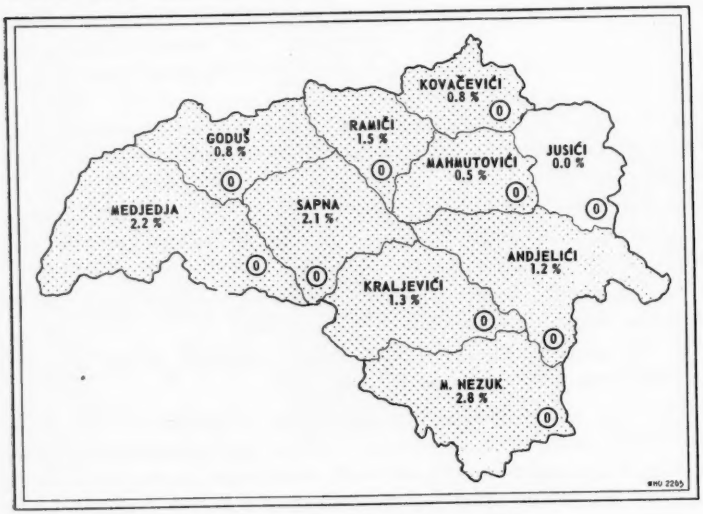
The work was divided among three teams composed of from eight to ten members each. The team leaders all had fairly extensive experience in specialized institutions and in the field. Each team was under the supervision of the health officer of the district and was responsible for one district at a time ; the average population of a district was 30,000-40,000.

FIG. 4. SEROPOSITIVITY-RATE AND NUMBER OF CASES OF SECONDARY SYPHILIS IN AN ADMINISTRATIVE UNIT (MNO SAPNA)

Systematic Examination and Treatment-2.X.1949 — Seropositive : 24.8%



Third Control Examination-10.I.1952 — Seropositive : 1.4%



○ Number of cases of secondary syphilis

The teams were generally subdivided, two members working in one village. A serological field-laboratory, manned by practised technicians, was at the disposal of each team. Blood samples were sent to the field laboratory and always arrived on the day they were drawn; there, qualitative Kahn and Meinicke tests were performed, a field laboratory being able to carry out approximately 600 tests a day. All cases of syphilis detected clinically or serologically were treated immediately.

The treatment was obligatory, and the people, who had been informed of the aims of the campaign, co-operated willingly. The team members remained in one place until the examinations had been completed and the treatment given, working all day and into the evening. As they gained experience, the teams succeeded in examining some 85% of the population during the first visit; during the subsequent control examinations, this proportion was increased to 95%. Those who were not examined were either persons absent from their homes or very young children in healthy families. Complete penicillin treatment was given in almost 100% of the cases, whereas, in previous control efforts with arsphenamine and bismuth, only 15% to 20% had completed their treatment.

Treatment

Procaine penicillin G in oil with 2% aluminium monostearate (PAM) was used in the campaign. In the early stages, PAM combined with bismuth was sometimes given, but the results obtained with this regimen were not different from those obtained with PAM alone.

At the start of the campaign, the treatment schedule was 3,600,000-4,200,000 units of PAM given daily or every second day in a total of six or seven injections of 600,000 units each. However, in certain cases the total dose was given in a shorter time, either in three injections of 1,200,000 units each or in a single injection; the results were equally good. It even seemed that in cases of seroresistance it was more effective to give the same quantity of penicillin in a single injection than in several. Thus, the single-injection schedule came to be adopted very frequently, and the results proved in no way inferior to those obtained with several injections. Re-treatment was given to all persons who were found at control examinations not to have responded satisfactorily to the original treatment.

It was not possible to determine precisely what the optimum interval between the initial examination and the re-survey should be, but the author considers that control examinations " should take place at intervals considerably shorter than two years so that fresh cases will not become foci for a further spread of infection in the area; and those cases should be detected and treated as early as possible ".

When the campaign started, it was believed that the chief risk in perpetuating the disease came from infectious relapses in cases where treatment had failed. It became evident, however, that the greatest risk was represented by infected persons who had remained untreated, by new cases of syphilis imported from other areas, and, particularly, by symptomless cases in the incubation period at the time of the original examination in whom infectious lesions subsequently developed. It thus became apparent that " the reduction of the reservoir of infection depends on... the abortive treatment of family contacts ", and treatment is now systematically given to all persons whose clinical and serological findings are negative but who are exposed to the risk of infection from other members of the household. The dose for abortive treatment finally adopted after various trials was a single injection of 1,200,000 units (4 ml) of PAM. Treatment with a dosage lower than that used for normal curative purposes is justified, as a smaller quantity of penicillin is required for treatment early in the infection. Experience has shown that abortive treatment must be given simultaneously to all family contacts.

Once all the contacts in a family, as well as all the cases, have been treated, no " relapse " or " seroresistance " will appear unless a fresh infection is imported from outside. There are reasonable grounds for supposing that a large number of so-called relapses or cases of seroresistance are actually reinfections, and the author cites as examples a number of families in which such reinfection occurred.

Results

Evaluating the results of the campaign, the author states:

" The reservoir as a whole has been brought under control, and the attitude of the people to the problem has been altered; this is due partly to some general improvement in social and economic conditions, partly to the work of the field teams and to the general progress of the campaign, and partly to the fact that new cases of endemic syphilis are now detected more rapidly and can be more rapidly dealt with.

" In our experience it is possible under favourable conditions ... to eradicate the infectious reservoir completely within a short period of time by mass treatment. In other cases, the disease can be checked and the infectious reservoir reduced to a minimum over a somewhat longer period and ultimately eliminated. In both instances true relapses and reinfections, and reintroduction of the disease from other areas must be watched for ... constant supervision of previously endemic areas is necessary as part of the long-term programme."

In Bosnia, such supervision is being provided by former field-team members who remain in areas where the campaign proper has come to an end and who co-operate with local health centres, which are assuming the responsibility for keeping the disease under control. This is part of a long-term programme which is serving as a " bridgehead " to the development of general public-health services and to the expansion of the machinery against all communicable diseases.

REGIONAL COMMITTEE MEETINGS

In September 1952, three of the WHO regional committees met in various parts of the world : the Regional Committee for the Americas (fourth session) in Havana, Cuba, from the 15th to the 24th; the Regional Committee for Europe (second session) in Lisbon, Portugal, from the 25th to the 27th; and the Regional Committee for the Western Pacific (third session) in Saigon, Vietnam, from the 25th to the 30th.

The Americas

Report on year's activities

In his report on the activities of the year, the Regional Director stressed the work in health demonstration areas, which represent long-range programmes for improving health conditions; the annual nursing workshops, which give training to regional nurses; the activities of the Institute of Nutrition for Central America and Panama; the fight against yellow fever, which continues to be a health problem in certain countries of the Region; the yaws-eradication campaign in Haiti; experiments with dry vaccine in smallpox-vaccination projects; and the work of the aftosa centre in Brazil. He called attention to the great expansion of the Organization's work and to the funds which are being made available for it through national technical assistance programmes, the Institute of Inter-American Affairs, the Rockefeller Foundation, the Kellogg Foundation, and the Organization of American States, as well as through the regular WHO and UNICEF budgets.

Fourth session of the committee

The meeting was attended by representatives from Brazil, Chile, Colombia, Costa Rica, Cuba, Dominican Republic, Ecuador, El Salvador, France, Guatemala, Haiti, Mexico, the Netherlands, Nicaragua, Panama, Paraguay, Peru, United Kingdom of Great Britain and Northern Ireland, USA, Uruguay, and Venezuela. Dr. Carlos Luis González (Venezuela) was elected Chairman, and Dr. Enrique Saladrigas y Zayas (Cuba) and Dr. César Vélez Morán (Ecuador), Vice-Chairmen.

The committee adopted a programme for 1953 which continues activities of the type reported for the previous year and approved a budget of about two million dollars. The proposed programme and budget of the Region for 1954 was transmitted to the Director-General. Among other decisions taken by the committee was approval of expenditure of an estimated $306,000.00 surplus of the Working Capital Fund for construction and alteration of the buildings of the interim headquarters; translation into Spanish and publication of the textbook *Principles of*

public health administration, by J. J. Hanlon; a programme for the eradication of smallpox; and the award of additional fellowships in 1953.

The next meeting of the committee will take place in Washington, D.C., from 14 to 25 September 1953.

Europe

Report of Regional Director

In a report to the Regional Committee for Europe, the Regional Director informed the members of action taken on recommendations made at its first session. In addition to problems of staffing of the Regional Office and selection of a site for the Office, the report deals with specific programme recommendations for 1953.

Second session of the committee

The following Member States were represented : Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Italy, the Netherlands, Norway, Portugal, Spain, Sweden, Switzerland, Turkey, the United Kingdom, and Yugoslavia. Also present were representatives from two Associate Members : Morocco (French Protectorate) and Tunisia. Dr. A. da Silva Travassos (Portugal) was elected Chairman, and Dr. E. Aujaleu (France) and Dr. C. van den Berg (Netherlands) were elected Vice-Chairmen.

In considering guiding principles for a general programme of work for Europe, the committee recorded its intention to review regularly such principles as they might apply as a result of further experience of the Organization's work in the Region. Since educational projects constitute an important aspect of WHO's work in Europe, the committee requested the Regional Director to transmit to the Director-General a suggestion that terms such as seminars, symposia, conferences, etc., be studied in collaboration with the United Nations and its specialized agencies with a view to arriving at mutually agreed definitions.

It was decided that the moment was not opportune for fixing the site of the Regional Office and that Member Governments should be consulted concerning their views on this matter. Provisionally, the Office will remain in Geneva for at least one year.

An account of the work of the International Anti-Venereal Disease Commission of the Rhine was presented, and a decline in venereal diseases along this river was noted; the committee consequently requested the Regional Director to consult with the governments of the countries concerned and with the International Labour Organisation as to the desirability of establishing a health and social commission to deal with the wider problems of the boatmen and their families. A report, together with a

financial estimate of the possible cost involved, is to be submitted to the committee at its third session.

A " redesign " of the 1953 programme was studied and two projects reconsidered and subsequently approved : a conference on health education, and a conference on teaching of preventive medicine. Programme proposals for 1954 were also discussed and approved.

The next session of the committee will be held during the first half of September 1953 in Copenhagen. An invitation from the Government of Yugoslavia to hold the 1954 session in that country was accepted.

Western Pacific

Second annual report of Regional Director

The report of the Regional Director to the committee described the development of health work within the Region during the preceding 12 months, as directed by regional advisers and an international field staff of 33 persons from 23 different countries. Among the activities were : maternal and child health projects in Cambodia, China (Taiwan), and Vietnam; nursing assistance in Brunei, Cambodia, China (Taiwan), Malaya, North Borneo, and Singapore; malaria-control projects in Cambodia, China, the Philippines, Sarawak, and Vietnam; tuberculosis-control campaigns, with UNICEF, in China, Hong Kong, and Singapore; planning for venereal-disease-control demonstrations in China (Taiwan), Hong Kong, and the Philippines; efforts against trachoma and bilharziasis; education and training activities, through granting of fellowships and sponsorship of seminars and symposia; and the work involved in arranging for the provision of medical equipment and supplies to a number of Member States.

Third session of the committee

Present at the meeting of the Regional Committee for the Western Pacific were representatives from Australia, Cambodia, China (Taiwan), France, Japan, Korea, Laos, the Netherlands, New Zealand, the Philippines, Portugal, the United Kingdom of Great Britain and Northern Ireland, and Vietnam. Dr. H. Marcel (Vietnam) served as Chairman and Dr. J. B. Mathieson (Australia) as Vice-Chairman.

Following its review of the proposed programme and budget for 1954 and of the approved regional programme and budget for 1953, the committee authorized the Regional Director to establish, if necessary, priorities for the implementation of projects. The priorities are to be based on following criteria : (1) value of the project to more than one country or to the Region as a whole; (2) the place of the project in the long-term health plans of the government concerned and the government's other intentions as regards the particular problem; (3) the association in the

project of more than one international health organization; and (4) the incidence of disease, the total amount of assistance being received from WHO, and the availability of other sources of assistance.

The Regional Director was requested to communicate to Headquarters the desire of the committee to hold an inter-regional rural malaria-control conference in the Region in 1954. The need for pooling information on public-health problems led the committee to recommend that a special study be undertaken on the possibilities of (1) establishing a clearing centre at the Regional Office for the collection and distribution of such information among the Member Countries, (2) encouraging more grants for intra-regional fellowships, and (3) sponsoring more intra-regional seminars.

Technical discussions on undergraduate medical education in the Region formed a part of the session and were so successful that similar discussions are to be included on the agenda of future meetings.

The meetings in both 1953 and 1954, which are to take place in either the second or the third week of September, will be held in Manila, unless invitations to hold them elsewhere are received in good time.

TRAINING COURSE FOR NURSING INSTRUCTORS IN MEXICO [1]

As in the majority of Latin American countries, one of the more urgent health problems in Mexico today is a lack of qualified personnel to give instruction to, and supervise the clinical practice of, student nurses. An additional problem is that of bringing up to date the curricula of nursing schools, which have become outmoded owing to rapid advances in medicine and to changes in nursing techniques. In an effort to solve these problems, the Ministry of Public Health and Welfare and the National Autonomous University of Mexico, which are entrusted with the training of nurses, sponsored a course for nursing instructors. WHO aid was requested and obtained, through the technical assistance programme. The course began on 14 January 1952 and lasted until 7 June; it included 880 hours of actual working time in the 21-week period covered.

Organization and Administration

An organizing committee was formed to administer the course. This was comprised of representatives of the Ministry of Health, the National

[1] This article is based on a report by Miss Hilda Lozier, WHO Nurse Consultant.

Autonomous University, the National Nurses Association, two hospitals with schools of nursing, and two public-health agencies. The committee outlined the course to be given, obtained the collaboration of eight hospitals and two public-health agencies, chose the instructors, set up admission requirements, and selected the students, five of whom were granted WHO fellowships.

There were 28 students, including directors and instructors from schools of nursing, supervisors of public-health services, and supervisors and head nurses from various hospitals. Their ages ranged from 19 to 25 years, and their professional experience and educational background were varied; 12 schools of nursing were represented. Since one of the objectives of the course was to teach teamwork, the students were organized in five groups of six students, each with one chief. These groups were rearranged every month so as to promote wider acquaintanceships among the students.

The Course

The course was divided into two periods : during the first, the student-instructors followed a programme in which social sciences, general nursing, and selected aspects of the principal fields of nursing were reviewed in great detail; in the second, they applied the knowledge gained during the theoretical part of their course in practice teaching under supervision.

The subjects taught included sociology (30 hours); mental hygiene (30 hours); clinical supervision and ward administration (60 hours); nursing history and ethics (20 hours); nutrition (30 hours); nursing—general, medical, surgical, paediatric, obstetrical, psychiatric, communicable-disease, and public-health—(368 hours); principles and methods of teaching (50 hours); and advanced Spanish (25 hours).

The nursing practice and studies were organized on a weekly basis : two weeks were devoted to general nursing, three to public-health nursing, and one week to each special field. All the practical work was done under the direction of Mexican nurses who had either studied abroad or who had had specialized training in their own country.

The practice teaching during the second stage of the course was done at the Nursing and Obstetrics School of the National Autonomous University of Mexico. Each student-instructor had full charge of four daily sessions, besides helping to supervise the students' work. Each received personal supervision in her classes, and a group of colleagues was always present at the classes and co-operated in the demonstrations. At the end of the day, the groups met for brief discussions of their activities.

Results

At the beginning of the course, a test on principles and concepts of education, supervision, and general nursing was given to determine the

educational status and competence of each nurse. When the same test was given at the end of the course, considerable progress was noted.

Perhaps the most effective evaluation of the work of the student-instructors was given by the students of the school of nursing at the University. Upon being informed that they were to be taught general nursing by instructors who were themselves learners, they called a meeting of the entire student-body of the school. It was decided that the first-year students would submit to the practice teaching and that if at the end of two days the classes were judged unsatisfactory the whole school would walk out on strike. This threat was never carried out; in fact, the student-nurses voluntarily gave up part of their April-May vacation in order to continue receiving instruction from the practice teachers.

The nursing school of the University underwent a transformation as a result of the course. Among the changes which were introduced were the following :

1. A ruling was made by which future candidates to the school of nursing must have a degree of " bachillerato " (12 years of study); previously only the secondary course (9 years of study) was required.

2. The University agreed to construct a special building for the school and granted the temporary use of a building for teaching purposes.

3. It was agreed that a permanent body of nurse-instructors should be maintained and that teaching facilities—rooms for classes and demonstrations, and fields for hospital and public-health practice—should be provided, all of which were non-existent at the University.

4. Teaching posts previously held by assistant physicians were assigned to qualified nurses.

THIRD SEMINAR FOR EUROPEAN SANITARY ENGINEERS

The third seminar for European sanitary engineers was held in London from 27 October to 1 November 1952, under the auspices of the Government of United Kingdom, the Rockefeller Foundation, and the WHO Regional Office for Europe. Particular stress was laid in this seminar on the need for co-operation between engineers and the other specialists who together make up a team of public-health workers. The participants, numbering about seventy and including delegates from 18 European countries, comprised sanitary engineers, chemists, health officers, bacteriologists, soil scientists, and others.

The number of recommendations made at the first and second seminars [1] was far too great to be covered at one meeting; it was therefore decided that the agenda for the third seminar should be based on one main technical theme—sewage works for small groups of houses and isolated dwellings, with particular emphasis on the septic tank—and on two secondary topics.

Papers on the main topic were presented by various specialists.[2] From the host country, Dr. J. A. Scott discussed public-health considerations; Lt.-Col. F. G. Hill and Mr. G. Lloyd Ackers dealt chiefly with the engineering aspects of the problem; Dr. L. A. Allen and Miss Hazel N. Smith compared the bacteriological results of treatment in large and small sewage works; and Mr. A. R. J. Pettet and Mr. E. E. Jones reported on the results of a two-year experiment in Great Britain on the performance of five small sewage-treatment plants. Professor F. J. L. Meinck, of Berlin, spoke on general factors governing sewage treatment and on particular experiences in Germany; Professor E. Leclerc contributed information on Belgian experiments comparing the working of septic tanks; Swiss investigations on the quality and disposal of effluent were considered by Mr. W. Dardel; and Dr. F. W. Mohlman summarized the most recent conclusions of the United States Public Health Service on small sewage plants.

One of the secondary items on the agenda—disinfection of water—was treated by Mr. L. J. Coin, of France. The other item—the role of the sanitary engineer—was reserved for examination at the Public Works Congress and Exhibition, whose opening in London followed the seminar.

Certain points received special attention during the discussions :

1. It was agreed that small sewage plants should be as free as possible from maintenance considerations. Methods of organizing, and intervals between, the indispensable minimum care were considered.

2. Although in some cases treatment with septic tanks alone might be satisfactory, it was felt by many that this should be followed by secondary processes such as percolation filtering.

3. The use of two-storey and multi-compartment tanks received much consideration. It was fairly generally agreed that the former should not be used for less than 30 people, and that more research on design was required.

4. The question of sludge disposal was raised several times. Emphasis was laid on the necessity for leaving some ripe sludge in the tank at the time of cleaning in order to seed the fresh sludge. Desludging at 6-month intervals was generally approved, with the proviso that a 12-month interval might be more suitable for very small tanks where sludge disposal was difficult.

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[1] *Chron. World Hlth Org.* 1951, **5**, 81; 1952, **6**, 40

[2] A comprehensive report on the main topic is in preparation.

During the seminar, participants visited a number of experimental plants on the outskirts of London, the Metropolitan Water Board, and a mains sewage system, which also collects sludge from scattered small plants. Methane gas from collected sewage is used to drive the pumps for the 55 miles of main sewers in the area, and the purified sewage is converted into fertilizer.

It had been recommended at the second seminar that information should be obtained on national associations of sanitary engineers with a view to the subsequent creation of an international association. Professor W. F. J. M. Krul had prepared a progress report on this topic. Mr. J. E. Holmstrom, of UNESCO, at the request of WHO, had made a list of dictionaries and glossaries of sanitary engineering terms, and gave suggestions on the preparation of a polyglot glossary.

Owing to the amount of work entailed in the preparation of a seminar, it was decided that the interval between seminars should be extended to 18 months. In that case, the fourth seminar for European sanitary engineers should take place in the early spring of 1954.

Reports from WHO Fellows

Many of the letters and reports received from WHO Fellows are of such interest that they deserve to be read by a wider public. They demonstrate more vividly than a series of facts and figures both the character of the fellowship programme and the response of the Fellows themselves. Selections from these reports are therefore published from time to time, but it must be emphasized that the opinions expressed are those of the Fellows.

Psychiatry in the USA, Great Britain, and the Netherlands

Dr. Paul Sivadon, médecin des Hôpitaux psychiatriques de la Seine, France, was enabled through a WHO fellowship to study trends in psychiatry in the USA, Great Britain, and the Netherlands. A résumé of some of his observations follows.

USA

A disturbing increase in the number of the mentally ill during the past ten years has confronted Americans with a problem which has suddenly become acute. In a population of 140,000,000, there are 700,000 persons hospitalized for mental illness. The number of beds occupied by neuropsychiatric cases represents almost half of the total number of hospital beds in the USA, and it is estimated that another 400,000 to 500,000 beds are

needed for psychiatric services, which are very much overcrowded. Psychiatrists number about 8,000 in all, but 18,000 are needed. Nurses, social workers, and psychologists are also lacking.

Americans have sought large-scale and drastic solutions for this problem. The essential features of the programme which they have undertaken comprise improvement and, particularly, expansion of hospital facilities; training of medical and auxiliary personnel; development of preventive measures and means for ambulatory treatment; scientific research; and publicity.

There are 600 psychiatric hospitals and about 900 outpatient departments, most of which provide ambulatory treatment. At the federal level, there are a research organization—an institute for mental health, which is one of the National Institutes of Health—engaging particularly in statistical studies at present but soon to include a centre for clinical research; and a large, 7,000-bed, psychiatric hospital, St. Elizabeths, in Washington, D.C. Other psychiatric hospitals include State hospitals (about half of the total number), municipal hospitals, Veterans Administration hospitals (for former servicemen), and private institutions.

The State of New York is among those with the greatest prevalence of mental illness. The State Department of Mental Hygiene is one of the most important of the State departments. It occupies the whole of the 18th storey of a large building housing the State offices at Albany and has annexes in Buffalo and New York City. It has charge of 120,000 patients hospitalized in 27 institutions. These institutions comprise 20 psychiatric hospitals (Pilgrim, the largest, handles 14,000 patients), six schools for backward children, and one hospital for epileptics. 25,000 people are employed by the Department, which has a budget of more than a million dollars. The organization is highly centralized, and an effort is made to standardize all activities, from the preparation of meals to methods of administering shock therapy.

As an example of a State hospital, Dr. Sivadon describes the organization and work of the Worcester State Hospital, in Massachusetts, which has 2,800 patients. This hospital employs about 700 persons, of whom 28 are physicians. Its facilities include a farm and workshops; occupational and industrial therapy is very highly developed. The medical work is carried out here, as almost everywhere, by a medico-social team. The social service division does everything possible to encourage leaves from the hospital and to facilitate contacts with the family environment. Efforts are also made to interest employers who come to visit the patients in attending conferences and participating in the rehabilitation of the patients. The role of the social workers in this hospital is very important; they are essentially the family therapists and deal with the " social " elements of the case in the same way in which the physician takes charge of the treatment of the patient. Co-ordination of the activities of the doctor, the psychologist, and the social worker is achieved through " team " meetings, at which the psychiatrist is the moving spirit and the leader.

In general, much attention is given in the USA to the problems of childhood. There are numerous child guidance clinics, but the number is still inadequate : some of them have waiting lists for from six months to two years.

Publicity is another aspect of the fight against insanity, and one in which cultural and social groups of all kinds collaborate.

The psychoanalytic influence which permeates psychiatry in the USA leads American psychiatrists to give much consideration to " psychosocial dynamics " and to attach importance to the role of psychologists and social workers in combating mental illness.

Great Britain

In this country the problem of insanity has been studied for a long time; the first legislation regarding the mentally ill dates from 1890. The British have come to realize that the problem of psychiatry has numerous and profound ramifications, that it is

primarily a social problem and that the treatment of the individual patient is only one aspect of a large whole. Thus, they have a wide variety of measures for prevention, treatment, and assistance. Many private organizations—such as the National Council for Mental Hygiene, the Tavistock Institute of Human Relations, and the National Institute of Industrial Psychology—seek to prevent the causes of pathogenic conflicts, through marriage counselling services or giving advice on maladjustment in school or at work, for example.

Certain psychiatric hospitals are concerned with the most antisocial forms of insanity (difficult, aggressive, and criminal patients). Others have many different types of treatment facilities. Every effort is made to keep institutionalized only patients who cannot benefit from other forms of treatment. The number of hospitalized patients is about 132,000 for a population of approximately 50,000,000 inhabitants.

The mentally deficient are cared for separately, most frequently in settlements. Private organizations (National Council for Mental Hygiene, the Mental After-Care Association, etc.) also aid in trying to place the mentally deficient in suitable institutions. An attempt is made to provide different types of aid through centres for ambulatory treatment, day hospitals, post-cure clubs, special farms for the mentally deficient, and special factories (Remploy Factories [1] and Thermega, Ltd.). Vocational rehabilitation is well organized. While the Remploy plants give work to both the physically handicapped and the mentally handicapped, Thermega, Ltd., which manufactures electric blankets, is reserved for the mentally ill. It employs 112 psychoneurotic workers, and its work can compete with other industries. Dr. Sivadon considers this an ideal form of assistance.

The Netherlands

In the Netherlands, psychiatric assistance is largely private. The various population groups (protestant, catholic, etc.) have their own institutions. These institutions are supervised by three psychiatric inspectors attached to the Division of Public Health of the Ministry of Social Affairs. The guiding principle of the administration is that every mentally ill patient should be able to receive treatment as easily and completely as any other type of patient.

The psychiatric services for a population of 10,000,000 comprise : dispensaries (giving short-term treatment, without formality) in all university centres and in some large cities; about 40 psychiatric hospitals (national, provincial, or private) taking care of about 26,000 patients; approximately 165 schools for mentally retarded children, handling more than 20,000 children, and day schools and settlements accommodating about 4,000 children; and numerous child guidance clinics. In addition, there are an excellent medico-legal organization and, in particular (at least at Amsterdam, the Hague, and Groningen), a noteworthy pre- and post-cure service, which assures the co-ordination of the whole.

There are workshops for the mentally deficient, for all levels and all ages. These are managed by private agencies. Many different types of work are performed in these shops by people who come in the morning and leave in the evening to rejoin their families. The value of their work is such that their products, in spite of a somewhat high price, are very much in demand. The city pays the agency for each person employed and grants a subsidy to make up for any deficit. This type of assistance is much more economical in some cases, particularly for the very retarded and for epileptics.

In some large cities there is a municipal mental hygiene service. At Amsterdam, six full-time psychiatrists for adults and three for children give continuous service. In this way it is possible to have immediate psychiatric aid when required. They attempt " orientation " without resorting to coercive measures, preferring to run certain risks

[1] See *Chron. World Hlth Org.* 1952, **6**, 368.

rather than to lose the confidence of a patient. In fact, antisocial actions on the part of the mentally ill have become very rare (for example, there are only five or six suicides per year) since they know that society will not subject them to any repressive measures.

* * *

Dr. Sivadon concludes that in the USA the keynotes are : construct hospitals, teach doctors, conduct scientific research, and educate the public. In Great Britain, the concerns are the same but are extended to include research on the psychosocial causes of the increasing number of cases of insanity and attempts at flexible and varied solutions, in keeping with the polymorphic nature of the disorders which are to be prevented and combated.

In the Netherlands, it is the private agencies which have taken the initiative in providing psychiatric assistance; the only problem is to co-ordinate their efforts. This has been achieved at the medical level to the exclusion of all repressive measures and administrative complications. In addition, research and publicity are carried out in a pragmatic way —with consideration for common sense, balance, and economy—which commands admiration.

Notes and News

Dr. Brock Chisholm to Retire Next August

Dr. Brock Chisholm, Director-General of the World Health Organization, has announced his decision not to accept the renewal of contract unanimously offered to him by the Fifth World Health Assembly. His contract expires on 21 July 1953, and the Assembly had proposed a prolongation of three additional years.

Dr. Chisholm was appointed by the First World Health Assembly as the first Director-General of the World Health Organization for a five-year period starting 21 July 1948. He had previously served for two years as Executive Secretary of the WHO Interim Commission.

Dr. Chisholm communicated his decision to the President of the Fifth World Health Assembly, the Hon. Juan Salcedo, Secretary of Health of the Philippines, in a letter dated 4 November. In his reply, Dr. Salcedo stated that this decision would be " a cause of deep regret to the World Health Organization, to which you have given your best and which you have served so well. I am certain I bespeak the sense and feeling of the Fifth World Health Assembly that, with your separation from the World Health Organization in your capacity as Director-General, the Organization shall lose its greatest exponent in the cause of world health." Dr. Salcedo communicated the Director-General's decision to the members of the WHO Executive Board. The Board meets in Geneva on 12 January 1953, and will have to consider a new nomination for submission to the Sixth World Health Assembly, scheduled to start in Geneva on 5 May 1953.

In a message to his staff, Dr. Chisholm explained that his decision not to accept the " generous offer " made by the Assembly " had not been made lightly, but after serious consideration of all the factors involved ".

" The major reasons for my decision ", Dr. Chisholm stated, " are that I believe that a permanent organization should not have the same head for too long, particularly at

the beginning of its history. There is a real difficulty in too firm identification of a world organization with one person. After two years with the Interim Commission and five with WHO, I feel that a change of Director-General bringing a fresh approach would be healthy...

"In every way it appears that WHO is in very good condition to stand the minor strain of a change in the person of the Director-General, a change which in any event would be inevitable in the not too distant future..."

Malaria Control in Burma

The malaria-control project undertaken in Burma in 1951 [1] has already met with considerable success. At present a team of about 25 Burmese workers, under the leadership of a Burmese expert on malaria and with the assistance of seven specialists and technicians from WHO, are carrying out operations in an area of 800 square miles (2,072 km²). DDT spraying has resulted in the virtual disappearance of malaria from villages where formerly one-third of the babies became infected with the disease during their first year of life. Blood smears from older people have revealed a general reduction of 80% in incidence of malaria.

The project is part of a five-year Government plan to give antimalaria protection to a total population of 7½ million persons by 1957. The technical assistance programme of the USA Government has furnished the necessary supplies and equipment. The WHO demonstration is serving as a training ground for personnel and is also affording an opportunity for scientific investigations which will be of value to the Government in its larger programme.

With WHO assistance, it is planned to give antimalaria protection to a population of 110,000, living in an area of 2,000 square miles (5,180 km²), during 1953.

Survey of Nutritional Diseases in Burma

A four-month survey, the most important ever undertaken in Burma, has revealed that 60% of the inhabitants suffer from nutritional deficiencies. The survey covered representative population groups : schoolchildren, dock-labourers, government clerks, nurses and social workers, and pregnant women and mothers. Most frequently observed signs of nutritional deficiencies were anaemia (especially among pregnant women, nursing mothers, and adolescents), glossitis, and xeroderma. It was found that the daily diet of the people lacked sufficient vitamin A, thiamine, riboflavine, iron, and calcium.

The survey was directed by Dr. R. Rao, WHO nutrition consultant and head of the nutrition department at the Haffkine Institute, Bombay. Among his recommendations to the Government of Burma were : (1) establishment of a nutrition department to study the incidence of nutritional diseases and to evaluate the foods in common use, (2) an experiment in schools to determine what supplementary foods would be acceptable to the people, (3) organization of community canteens for certain groups of the population, and (4) instruction of the people in the principles of nutrition. Dr. Rao advised against the milling of rice, which removes much of its food value; recommended the manufacture of vitamin tablets from locally available material; and stressed the need to popularize milk as a food.

The Government of Burma is considering the establishment of a national nutrition council. Also, acting upon Dr. Rao's advice, the Government will request additional WHO fellowships in 1953 and 1954 to enable Burmese workers to go abroad for study of modern nutrition.

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[1] *Chron. World Hlth Org.* 1952, **6**, 53

Two Physiotherapists Sent by WHO to Bombay

An investigation conducted in 1950 by a WHO team of experts on poliomyelitis revealed that this disease is responsible for 20% of the crippling of children in India, and that there are thousands in need of rehabilitation. The team observed that the medical centre of the King Edward Memorial Hospital, Bombay, had been giving poliomyelitis treatment for 15 years, but that it could not fulfil the needs of the country.

Following this survey, the Government of India requested WHO aid in establishing a modern centre for physiotherapy. The Organization has provided part of the teaching equipment for this centre. Recently, two physiotherapists were sent to Bombay: Mr. R. J. Jacques (United Kingdom), who was formerly senior physiotherapist at the Orthopaedic Rehabilitation Annexe at Perranporth, Cornwall; and Mrs. P. C. Mehta (USA), who, until 1951, was assistant to the chief therapist at the Goldwater Memorial Hospital for the physically handicapped, New York, N.Y. Mr. Jacques and Mrs. Mehta will utilize the existing facilities at the King Edward Memorial Hospital to help develop training in physiotherapy, as an integral part of a rehabilitation programme.

WHO Activities in the Eastern Mediterranean Region

Iran

Dr. A. A. Smahl (USA), an expert consultant on venereal diseases, was sent by WHO to Iran at the beginning of December 1952. There, with the aid of a serologist, a public-health nurse, and a matching team of Iranians, he will direct a survey of the incidence of syphilis in Teheran and the surrounding region. He will also participate in training personnel from the various provinces so that the survey and treatment activities may be extended throughout the country.

Dr. L. Lewis, industrial health consultant from Berkeley, California, USA, has returned from Iran, where he was sent by WHO, at the request of the Iranian Government, to study health and safety conditions in industry.

Iran, which used to be a purely agricultural country, has, in the past twenty years, had to face all the various steps in industrialization, but social progress has not been able to keep pace with the changes which this industrialization has brought about. Today Iran is engaged in industrial activities which make use of the raw materials of the country: spinning and weaving of cotton, wool, and silk; refining sugar; milling flour; preserving food; processing tobacco; husking rice; and drying tea. These industries employ 57,000 workers; heavy industries, such as railroads, mines, and oil concerns, employ another 150,000 persons; and an additional 150,000 work at handicrafts, such as carpet-making, in which conditions differ little from those in factories. Thousands of inexperienced people from rural regions have had to adapt themselves to industrial life. Although their adaptation has been excellent, it has become urgent to protect and improve the health of the workers, to provide industrial benefits, and to promote industrial safety.

The Government has already enacted, and partially applied, a labour law which contains some excellent provisions and which Dr. Lewis thinks may serve as a basis for a programme of health protection and social security. However, Iran lacks the technical personnel for carrying out such a programme. Dr. Lewis has recommended that WHO and ILO aid in training personnel and in setting up a security scheme which will establish good sanitary and safety conditions in industries, and the eventual integration of occupational health services into the country's public-health programme.

Hashemite Kingdom of the Jordan

During October and November 1952, a WHO expert on mental health, Dr. A. Milne (Scotland), conducted a survey in Amman of various problems concerning the treatment of the mentally ill in Jordan.

Lebanon

A maternal and child health centre (WHO/UNICEF-aided) was opened in Beirut at the beginning of August 1952. Intended to serve as a demonstration and training centre for local personnel, the centre has organized services for pre- and post-natal care, the prevention of diseases, and domiciliary care, and has arranged refresher courses for doctors and nurses.

Pakistan

A venereal-disease clinic is being constructed at Karachi. International and Pakistani personnel will be under the direction of Dr. F. R. Curtis, consultant in venereal disease at the Whitechapel Clinic, London, who has been given two years' leave of absence to work for WHO.

With UNICEF and WHO assistance, the Government is erecting, at Dacca, an antituberculosis training and demonstration centre. Elsewhere in the country—in Punjab, East Bengal, Baluchistan, and the North-West Frontier Province—teams of international and Pakistani personnel are continuing a BCG-vaccination campaign.

Syria

A maternal and child health centre (WHO/UNICEF project) is to be opened in Damascus, Syria. A WHO team, composed of a French physician, Dr. H. Humann, and a public-health nurse, Miss J. Lund, of Copenhagen, will train Syrian doctors and nurses for work in all parts of the country.

A malaria-control demonstration has been initiated in the region of Homs. The team leader is Dr. J. Deniaud, of France. This project includes an entomological survey of the malaria vectors, DDT-spraying operations, and training of national personnel.

Dr. Brock Chisholm Receives Lasker Award

At its 80th annual meeting, held in Cleveland, Ohio, USA, in October 1952, the American Public Health Association bestowed the Lasker Awards for the year upon six men distinguished by their contributions to medical research and the improvement of public health. These awards are considered among the highest medical honours in the USA. Dr. Brock Chisholm was the recipient of one of the awards, conferred upon him " for uniting the nations of the world in successful and constructive collaboration to attain the highest level of health for all their people ".

Publication on the Regional Office for South-East Asia

The Regional Office for South-East Asia has published a new edition, revised and expanded, of an information handbook [2] which first appeared in 1951. This booklet, of some 30 pages, is designed to give health workers in South-East Asia information concerning the role of WHO, its organization, its history, and the types of assistance

[2] World Health Organization, Regional Office for South-East Asia (1952) *WHO information handbook, South East Asia Region*, New Delhi

which it can offer (sometimes in collaboration with other agencies) to governments in the Region. The financial aspects of such assistance are explained, as well as the different steps to be taken by governments desiring WHO aid. Appendices give a list of the international personnel at work in the Region as of 31 October 1952 and a brief catalogue of WHO publications.

Film on Malaria in Thailand

" The ancient curse ", a film which shows the ravages of malaria in Thailand and the activities of a WHO antimalaria team in combating them, was exhibited in various cities of Europe during October and November. Special showings were given in Berne, Bonn, Helsinki, the Hague, Stockholm, and Ankara; national premieres were held in Lisbon, London, Madrid, and Paris. The film has enjoyed considerable success at United Nations Headquarters in New York, where it was being shown three times a week. Dr. Brock Chisholm has said of this film : " I am sure that the dramatic story of the fight against malaria in North Thailand, as told by ' The ancient curse ', will bring home to millions of people what effective international co-operation can do to create a healthier, more prosperous and better world."

German Publication Concerning WHO

Number VI of a series of documents on international organizations, published by the University of Hamburg (Germany),[3] is devoted to WHO. Dr. L. Dischler describes the various stages in international collaboration in the field of health, ending with the creation of WHO and describing the Organization's activities during the past few years; he gives a brief account of successful disease-control efforts in certain countries. In the second part of the booklet there is a German translation of the WHO Constitution, with the accompanying English text, and of the International Sanitary Regulations.

[3] Hamburg. Universität. Forschungsstelle für Völkerrecht und ausländisches öffentliches Recht [1952] *Weltgesundheits-Organisation (WHO) und Internationale Gesundheits-Ordnung*, Dokumente VI

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